C+D
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news education
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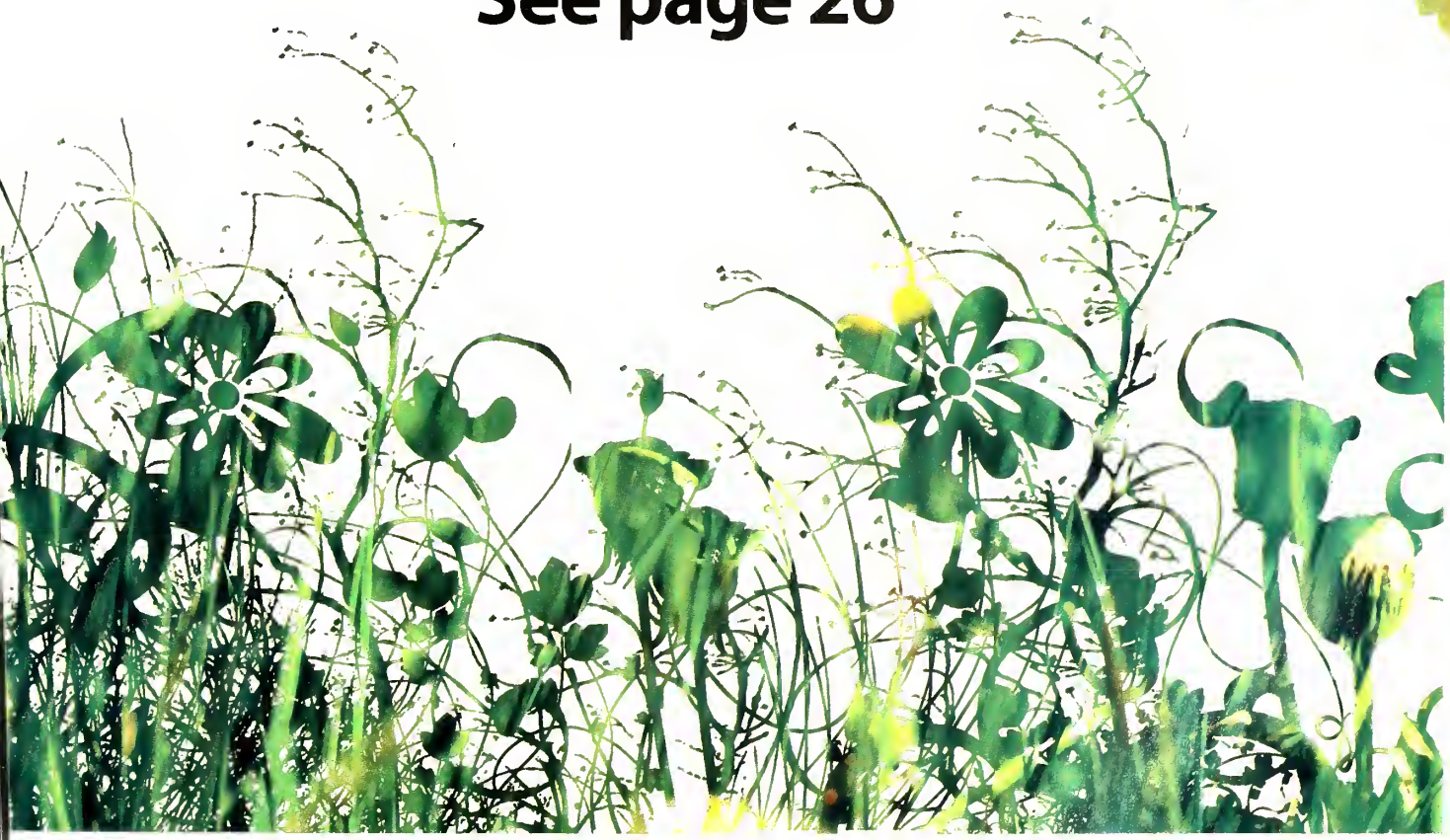
3 May 2008

Summer health

Your passport to blossoming sales in suncare, allergies and travel health

See page 26



HIGH POLLEN COUNTERED FAST.

- **Benadryl Allergy Relief contains Acrivastine, which gets to work in just 15 minutes.**
- **The No.1 selling hay fever brand worth £13M.***
- **Supporting you this season with a £4M campaign including TV and press.**

*IRI Market Value Sales; MAT to 23rd February 2008

The fastest acting allergy capsule.

Benadryl Allergy R... Product Information: Presentation. Acrivastine 8 mg capsules **Uses.** Allergic rhinitis. Also chronic idiopathic urticaria **Dosage:** Adults and children aged 12 - 65 years ...ne cap... to 3 times a day **Contraindications:** Hypersensitivity to acrivastine or triprolidine. Significant renal impairment. **Precautions:** Caution when engaging in activities which require ...erness until familiar with response to drug. Concomitant use of acrivastine with alcohol or other CNS depressants may produce additional impairment. Caution when taking with ketoco... erythromycin or grapefruit juice **Pregnancy & lactation:** Not recommended **Side effects:** Rarely drowsiness. **RRP (ex-VAT):** 12s £3.70, 24s £6.42 **Legal category:** 12s GSL, ...s P **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS. **PL number:** 12s 15513/0128, 24s 15513/0035 **Date of preparation: May 2007.**

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Chemist + Druggist
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Comment from the Editor

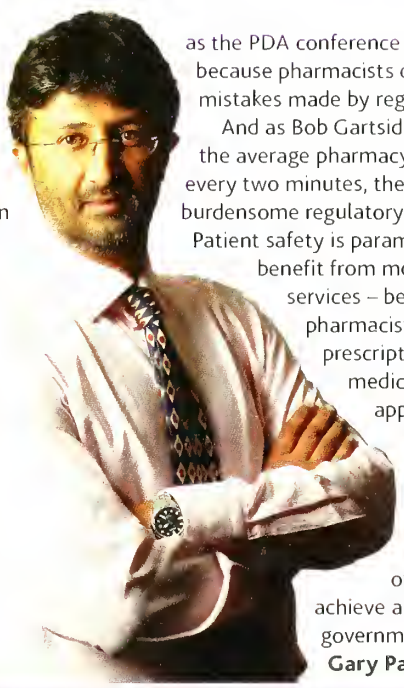
White paper aside, two letters this week on workloads and the way that the RPSGB tackles minor dispensing errors (pages 14 and 16) highlight two of the more immediate concerns of community pharmacists.

Professor Joy Wingfield, a former RPSGB inspector and head of ethics, raises the inequitable way that community and hospital pharmacists are regulated (p16). It's bad enough that every dispensing error in the community can result in a criminal offence, but when the 'error' is merely administrative, for example a late recording of a private prescription, then the threat of punishment is unjust and unfair.

While the RPSGB's consultation on the referral criteria for its investigating committee is a step in the right direction, there needs to be a more fundamental review of the way that community pharmacy is policed. Pharmacy is not alone as a health profession that treats patients in a community setting, yet it is the only one with a dedicated inspectorate.

Without doubt, this overt disciplinary mechanism has had an effect on the way that community pharmacists practise. Despite the introduction of services that make better use of their clinical training, why do pharmacists at the coalface feel compelled to oversee every aspect of the dispensing process?

Does a pharmacist's final check on a repeat prescription, where there has been no material change in six months, add any patient value? Or is it perhaps, as the PDA conference debated last Sunday (p5), because pharmacists could still be liable for mistakes made by registered technicians?



And as Bob Gartside's letter adds (p14), with the average pharmacy now dispensing one item every two minutes, there is a need for a less burdensome regulatory mechanism.

Patient safety is paramount but, if patients are to benefit from more clinical pharmacy services – be it MURs or screening – then pharmacists need to know that prescriptions can be dispensed and medicines sold under SOPs by appropriate staff without fear of personal liability.

Regulation should not hinder the development of services that benefit patients, otherwise we will fail to achieve any of our or the government's aspirations.

Gary Paragpuri, Editor

Contents

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RPSGB members will get a say on royal college inquiry

Society intends to act in bid to stave off criticism

Rob Finch

The Royal Pharmaceutical Society has promised its members a chance to respond to the issues raised by the independent inquiry into the formation of a professional body.

Council members last week committed to consulting the membership on the Society's response to the Clarke Inquiry. It is understood to have made the decision in order to stave off criticism that it is repeating past mistakes.

Council member Graham Phillips said: "There's a commitment to consult the membership in a meaningful way that isn't a yes or no.

"We need to keep the members involved throughout, without presenting them with a *fait accompli*. This can't simply be the Council, we need to engage with the broader pharmacy stakeholders."

Mr Phillips added that personally he would like to see this engagement take the form of a web-based questionnaire on Clarke's recommendations.

Council also agreed to the transitional committee suggested by Clarke to oversee the move to the new professional body, including an independent chairperson. But it stopped short of suggesting candidates for the position.

The Institute of Pharmacy Management also responded to Clarke's recommendations this week, saying the timelines for setting up the new professional body were not realistic.

If put in place in the 18 months allotted, the process would be "rushed", the IPM said, urging an extension until mid-2010.

Graham Phillips: pledged to keep the members involved

Will you respond to the consultation?
mgosney@cmpmedica.com

Society reserves are on the up

The RPSGB has reported an improvement in its financial reserves, but delivered a pessimistic forecast in light of the current financial climate.

In its annual review for 2007, the Society recorded an operational deficit of £216,000 compared with a surplus of £210,000 the previous year.

Taking into account tax and a boost from the pension fund valuation, its total accumulated reserves increased to £8.6 million.

However, the review notes that the pension benefit will be "short-lived" following adverse market changes in the early part of this year. "Continuing careful management of the Society's reserves is required," it stated.

Overall, income grew 6.5 per cent year-on-year to £35.3m, with fees contributing £14.7m.

Expenditure was up 7.7 per cent. Costs related to fitness to practise and legal affairs rose 31 per cent to £4.7m. In addition, the Society spent £422,000 on the split of its regulatory and professional leadership roles.

Treasurer Andrew Gush said: "It has been well reported that the Society is facing a number of financial challenges."

Though the 2007 review does not reflect 2008's 50 per cent retention fee hike, Society chief executive Jeremy Holmes said it had "taken lessons from the significant issue". He added: "Members have never been more vocal and the Society has remained open to receiving comment and criticism." **JR/TH**

Repeat dispensing a missed opportunity

Pharmacists have "missed a trick" in failing to provide repeat dispensing services, which could have strengthened their relationships with GPs, the Department of Health's primary care lead has said.

David Colin-Thomé, national lead for primary care at the DH, spoke at the AAH Convention that in his experience, pharmacists did not want to provide the service, and some wanted to wait for the electronic prescription service to come in.

He said: "I'm not saying every GP would, but a lot of us would have loved to take the burden of repeat dispensing and repeat prescribing off general practice."

But pharmacy experts said GPs themselves had proved difficult to involve. Gareth Jones, NHS liaison manager at the NPA, said that engaging GPs was a challenge. **ZS**

David Colin-Thomé on GP-pharmacist relationships, see p10

C+D's Building Bridges campaign stretched the length of England this week, with MPs visiting pharmacies in Doncaster, Gloucester and Essex.

Rosie Winterton, Labour MP for Doncaster Central, was shown a newly-installed dispensing robot at Weldricks Pharmacy's Armthorpe branch, by superintendent Richard Wells (right).

Ms Winterton said she was delighted to have been invited: "Pharmacists play a vital role for local communities."

Parmjit Dhanda, Labour MP for Gloucester, chatted to Rowlands pharmacist manager Aitzol Calleja about the changing role of the profession, and discussed the potential for taking on additional services such as smoking cessation and weight management.

Mr Calleja said: "The MP left saying he felt he now had a better base to read, understand and comment on the white paper... it was definitely worth taking part in the campaign."

In Essex, the Conservative MP for Castle Point, Dr Bob Spink, pledged his support for Pharma Healthcare's 'Use Us or Lose Us' campaign after meeting contractor Nader Siabi (see above right).

Contractor's campaign set for Westminster

Canvey Island pharmacist aims to highlight polyclinic danger

Jennifer Richardson

One contractor's fight against a planned polyclinic is making its way to Parliament this week, after his local MP pledged support.

Nader Siabi, of Pharma Healthcare on Canvey Island, Essex, launched his 'Use Us or Lose Us' campaign to highlight to local people the danger he says Central Canvey Primary Care Centre will pose to the provision of pharmacy services on the island.

Conservative MP Dr Bob Spink backed the campaign after visiting Pharma Healthcare last week, as part of C+D's Building Bridges, a push to raise the profession's political profile.

As a result, Dr Spink has tabled four parliamentary questions this week, including one asking health secretary Alan Johnson for his assessment of the impact of polyclinics on independent community pharmacies.

"[Mr Siabi] provides a great community service, as many pharmacies do. They are the heart and soul of our communities and our high streets," Dr Spink said. "We have to try and do everything we can to support them."

Five of the Canvey Island's nine GP surgeries along with a community pharmacy, the contract for which is held by Alliance Boots, will move into Central Canvey Primary Care Centre when it opens in February 2009.

South East Essex PCT has said the decision to include a pharmacy in the centre was based on public consultation, and that the granting of the contract to Alliance Boots "was based not only on the best value financial outcome to the NHS, but the highest standard of service for patients".

But both Mr Siabi and Dr Spink believe PCTs make decisions about polyclinics on a financial basis, without due consideration for local service provision.

"More of these centres are being built in the country and more will find it difficult to make ends meet, because they will effectively take control of the prescription flow," Mr Siabi said. "My aim is to highlight the plight of a lot of pharmacies, not just me."

Building Bridges extends

Profits key to polyclinics, claim Tories

Pharmacies are to be used as financial leverage to open more polyclinics across England, shadow health secretary Andrew Lansley has claimed.

In a new line of attack on government plans, to be laid out in the final Darzi report, Mr Lansley claimed each new polyclinic would cost £800,000 to set up. The profits from pharmacies inside the centres would be a key component in their success, he said.

"Polyclinics are expensive; they cost about £800,000 each. I suspect the government intends to ensure that they have a large pharmacy, which will take the pharmacy profits."

Mr Lansley added that many GP surgeries could face closure as a result of the schemes.

Health secretary Alan Johnson rejected the attack, saying: "There is no national policy for replacing traditional GP surgeries with health centres or, indeed, polyclinics." **CB**

Would you move into a polyclinic?
haveyoursay@cmpmedica.com

News in brief

NPA leadership team

Paul Bennett, professional standards director and superintendent pharmacist at Boots, will chair the NPA in 2008-09. Ian Facer, who represents NPA members in the north-west, was elected as vice-chairman, and Wally Dove, representing members in the south, was reappointed treasurer.

Paraffin product SOP

The NPA has launched a template SOP and guidance notes for the supply of paraffin-based skin products. It includes a template patient information leaflet to help pharmacies advise patients of the risk of fire associated with the products.

Research bursaries

Pharmacists interested in developing their skills in pharmacy practice research can apply for bursaries from the Pharmacy Practice Research Trust. The deadline for applications is May 23, and interested pharmacists should contact Beth Allen on 020 7572 2466 or beth.allen@rpsgb.org.

Uncertainty over liability

There is "considerable uncertainty" over who takes responsibility when a registered or accuracy checking technician makes an error. Professor Joy Wingfield told PDA annual conference delegates the answer could depend on factors such as the employment status of the pharmacist and the tribunal or court hearing the case. Read Prof Wingfield's letter on page 16.

Diabetes institute

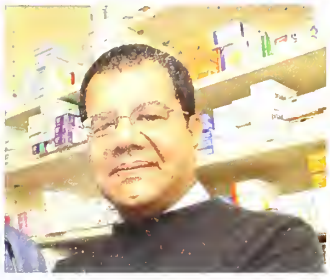
The first dedicated Institute of Diabetes for Older People (IDOP) in Europe will be launched at the University of Bedfordshire this month. IDOP will work with health professionals and the public to improve the health and well-being of ageing adults with diabetes and related problems.

Climate commitments

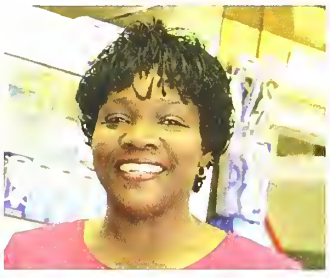
Several high street retailers including Boots have pledged to combat climate change by cutting emissions from buildings and vehicles, and helping customers and staff reduce their environmental impact.

Dispensary TALK

Could polyclinics be good for pharmacy?



"Polyclinics are fine – providing they don't affect existing networks. Locally we've got a good network of pharmacists providing excellent services to patients. If a polyclinic was to be detrimental to that, then it would be a bit of a disaster."
Sunil Bajaria, Worthcare Pharmacy, Thamesmead



"Definitely – if you've got everybody else there without a pharmacy you've not really wrapped it up for the patient. Without pharmacy it's not the complete package."
Aina Osunkunle, K and A Pharmacy, Gateshead

WEB VERDICT:

Yes: 42%
No: 55%

[illegible] pharmacists have been accused [illegible] with a united voice, [illegible] seem divided on the [illegible] way or the other, it seems [illegible] are a black and white issue [illegible] anybody prepared to sit on the fence.

This week: Are GPs hindering [illegible] to set up repeat [illegible]
[illegible]chemistanddruggist.co.uk

Union plans gather pace

PDA intends to boost membership numbers and target companies

Zoe Smeaton

The Pharmacists' Defence Association (PDA) has outlined plans for the development of its new trade union.

PDA chairman Mark Koziol said the union would be looking to boost membership and target employees from specific organisations. If the union had 50 per cent of employees from any given company as members, it would have improved bargaining tools with that company, he said. "It means we're in head office and we're talking, and we're not just having a cup of tea and a biscuit."

Speaking at the PDA's annual conference last Sunday, Mr Koziol also said the union would be looking to influence the formation of the planned professional body, possibly by putting PDA members up for elections. He promised extra services for PDA members later in the year.

The aims of the union include: protecting the terms and conditions of members; representing, defending and supporting members; and providing benefits and legal representations for members.

Mark Koziol: bargaining tools – not just a cup of tea and a biscuit

Over the next year the PDA will also be extending its student membership scheme, aiming to protect students from potential fitness to practise investigations and educate them about the expectations of them.

Heena Bhakta, president of the British Pharmaceutical Students' Association, welcomed the moves and said she hoped the group could work together with the PDA.

Will you join the PDA union?
zsmeaton@cmpmedica.com

Referral plans under fire

The RPSGB's plans to reduce the number of pharmacists being referred to the investigating committee (IC) for dispensing errors have come too late, according to the PDA.

The association said it welcomed the general thrust of the plan, but Mark Koziol, PDA chairman, added: "This should have been done five years ago, hundreds of pharmacists could have been saved the humiliation of having to go through that dreadful process known as referral to the investigation committee."

Mandie Lavin, RPSGB director of fitness to practise and legal affairs, said all responses to the Society's consultation would be considered.

For more details go to www.chemistanddruggist.co.uk

Prescription plan needs funds

Information prescriptions, which pharmacists could soon be asked to provide for patients across the country, should be implemented with care and need funding, pharmacy experts have warned.

The prescriptions require pharmacists or other healthcare professionals to talk to patients, asking what additional information about their condition, medication, social care or other related issues they would like.

The professional will record this on the prescription, which can be sent through to a provider such as NHS Direct, which passes the information on to patients.

Plans to implement the service will be determined locally, but in pilots, consultations and form-completion with patients have taken around 12 minutes.

Saghir Ahmed, from the Co-operative Pharmacy, who took part in one of the pilots, said funding would be necessary, "especially in a climate where there's less and less money for pharmacy".

And Andy Murdock, pharmacy director at Lloydspharmacy, called for the service to be embedded within contractual frameworks.

NPA NHS liaison manager Gareth Jones said providing the prescriptions was "a natural extension of the pharmacist's current role". **ZS**

Charity backs pharmacy's role in antipsychotics

A dementia charity has called for greater involvement of community pharmacists in the prescribing, monitoring and review of antipsychotics.

The recommendation was included in a report from MPs that demanded the drugs be only a "last resort", because of fears they are being over-used.

The all-party parliamentary group on dementia reported: "[The charity] For Dementia suggests that there is scope for greater involvement from community pharmacists who prepare and dispense the prescriptions to care homes.

"These pharmacists should have greater responsibility in ensuring prescribing protocols are adhered to and the medication is reviewed regularly."

The MPs were worried about the "very harmful" side effects of antipsychotics, including a tripling of the risk of stroke. **RF**

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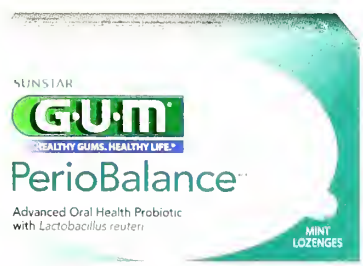

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1. Çaglar E et al. Oral Disease 2005; 11. 131-137

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News in brief

SPB open day

At the RPSGB Scottish Office's inaugural open day in Edinburgh last week, Scottish Pharmacy Board chairman Dr Rose Marie Parr updated members on roadshows that will give them the chance to share their views on what they want from their professional body.
www.chemistanddruggist.co.uk

Hypertension guidance

Guidance for pharmacists on how to assist patients in managing hypertension has been issued by the RPSGB. It has been updated to reflect the changing role of community pharmacists as they take on more clinical responsibilities.

Norton settlement

The Scottish Government has agreed settlement of civil claims against an international pharmaceutical company for alleged anti-competitive cartel conduct in the supply of drugs to the NHS. Norton Healthcare Ltd and Norton Pharmaceuticals Ltd have agreed, on a full and final basis and without admission of liability, to pay £2,837,500 compensation.

PM visits pioneer centre

Prime Minister Gordon Brown visited the Boots Centre for Innovation in Swansea last week. The centre was set up a year ago to identify and support the development of pioneering health and beauty products. It has received more than 400 health and beauty ideas from inventors.

NCSO endorsement

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsements for the following item for April prescriptions: bisacodyl 10mg suppositories.

Royal welcome

Midlands pharmacist Sukhjihan Gill was on hand to introduce HRH The Prince of Wales to Apnee Sehat – "Our Health" in Punjabi – in Coventry last week. The lifestyle intervention programme aims to combat premature diabetes in the south Asian community, where traditional cooking involves high levels of sugar and fat.

DDA 'attacks' rival dispensing profession

Doctors' association should put aside professional differences, says RPSGB president

Jennifer Richardson

Pharmacies are not yet accepted as a proper location for health services, the Dispensing Doctors' Association has claimed.

A Department of Health-commissioned survey on community pharmacy use, published alongside the pharmacy white paper, showed that 84 per cent of adults in England visit a community pharmacy at least once a year, and that 74 per cent do so for health reasons.

But, in response to the survey, the DDA's Dr Paul Thomas reported on its website: "There are no surprises for learning that the main use of pharmacies is to obtain medication prescribed by a doctor."

RPSGB president Hemant Patel called the organisation's comments an "attack" on the profession and "a clear effort to protect dispensing doctors' income".

Few respondents to the survey reported using services such as health screening and smoking cessation, Dr Thomas said. "All of which tends to confirm that the pharmacy is not, yet, accepted as a proper location for the provision of these services."

Dr Thomas was reassured to see that pharmacies "tended to be mentioned after the doctor and NHS Direct as a likely source of information".

Mr Patel said the comments were disappointing: "We want to work collaboratively with the DDA to recognise the needs of the public and put aside professional differences."

A campaign to raise awareness of pharmacy services has been relaunched by the NPA. Ask Your Pharmacist (AYP) 2008 will feature posters within 200 metres of 1,200 pharmacies around the UK, on billboards and telephone boxes. The posters' focus will move from MURs to health checks and then sexual health services throughout the year, and NPA members will be given corresponding posters to display in their pharmacies
www.askyourpharmacist.com

Pharmacy graduates: more employable but less payable?

Pharmacy graduates are some of the most employable in the UK, according to research.

But earnings for pharmacy graduates appear to be significantly below rivals such as medics and dentists, The Independent's Good University Guide has suggested.

More than two-thirds of pharmacy and pharmacology students are employed in graduate jobs, putting them third highest. But their graduate salaries are just £18,491, leaving them in 26th place, just above degrees in American studies.

Heena Bhakta, president of the British Pharmaceutical Students' Association, warned that combining pharmacy and pharmacology may have skewed salaries downward.

But she added: "When you start off as a basic grade pharmacist you go in on quite a low-ish pay scale, but it shoots up, whereas other people might get £20,000 in their first year and not go up for 10 years."

"At the moment, there's lots of jobs for pharmacy, but... with the numbers of schools of pharmacy opening there'll be more graduates than jobs and we'll struggle." **RF**

New NPA chief executive pledges practical help

The NPA is gearing up to be "very vocal" on the implementation of proposals made in the white paper.

Chief executive John Turk said the government blueprint for the profession, published the week before he took the helm, was "a tremendously positive thing".

But, in his first interview since taking up the post, he added: "The challenge now comes down to what that means in implementation. We need to be very vocal on behalf of our members in terms of practical issues."

This would include equipping pharmacists with the skills to negotiate local service specifications, and assessing the need to increase staffing levels and skill mix. Mr Turk said: "There's huge investment there in potential human resource." **JR**

Don't miss C+D's exclusive interview with John Turk in next week's issue

John Turk: do we need to assess staffing levels and skill mix?

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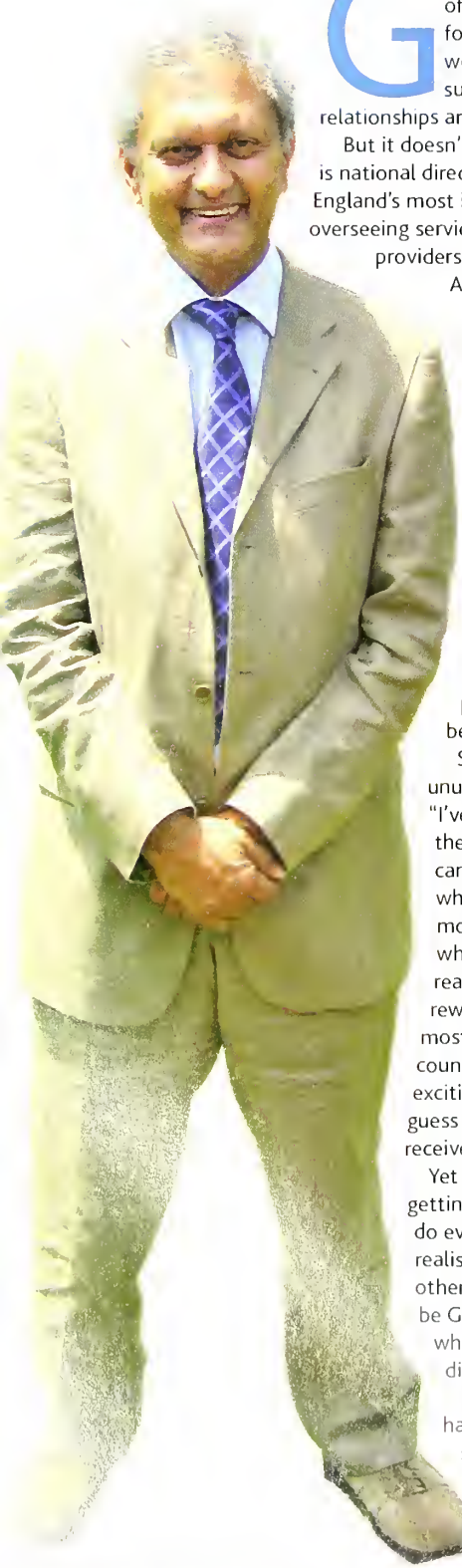
Love thy GP neighbour

GPs: for many pharmacists it's a case of can't work with them, can't work without them. At the AAH Convention **Zoe Smeaton** talked to the most high profile GP of all, David Colin-Thomé, about the future for the two professions



General practitioners: what do you think of them? The chances are, not a lot, for while some pharmacists are able to work in harmony with their local GPs, success is patchy, and for many, relationships are fraught.

But it doesn't have to be this way. David Colin-Thomé is national director for primary care, making him one of England's most influential GPs, but his role includes overseeing service frameworks for all primary care providers, including pharmacy.

Although "early work", Dr Colin-Thomé says the pharmacy white paper fits well with the development of more integration between professional groupings, as well as enhancing clinical roles for pharmacists. This is in line with broad primary community care strategies, moving away from care being provided solely by GPs and looking to other providers as well, he says.

But will such moves ever be possible given the attitudes of many doctors?

On this Dr Colin-Thomé is clear: "Lots of GPs won't like it and will see it as competition... as encroaching on their preserve, so there will be some tensions."

Such moaning is not unusual, though, he says. "I've worked 40 years in the health service and I can't remember a year when there wasn't low morale; aren't we a whingeing lot? There's a real issue here, our rewards are better than most people in this country and, for most if us I think, it's an exciting clinical experience, but you wouldn't guess it from the amount of whingeing that I receive on a regular basis."

Yet he is hopeful that as GPs realise it is getting more and more difficult for them to do everything themselves, there will be a realisation that they have to work with others to provide care. "There will obviously be GPs who don't like it and pharmacists who don't like it but it's an inevitable direction of travel."

One issue between pharmacists and GPs has been the commissioning of local services. As separate providers, it is right that the two should be competing with one another, yet with GPs sat around the commissioning table, pharmacists have often felt they are losing out unfairly.

Dr Colin-Thomé recognises the difficulties with commissioning. "It's a hard job to commission, because all the power and status resides... with providers and many of us aren't always the most objective in the use of resources." He says the Department of Health is spending lots of time trying to upskill PCTs though, to help them commission effectively in the future, so perhaps things will improve.

In the meantime he urges pharmacists to try to forge links with local doctors. He says we are "too simple" in the health services. "We either see collaboration or competition as two separate entities, when actually we should be competing on things where it would make us more responsive to our patients and collaborating when it would be for our patients' gain. That's a more mature response which is much more common in private industry."

And despite their differences, there is one issue on which he says pharmacists and GPs are agreed. The idea of polyclinics has been "going down like a lead balloon amongst general practitioners". But he says we should be clear that the idea is not to have lots of "GP factories distanced from their patients in one big impersonal service", but instead to provide extended services.

He believes some of the negative press is because of Eastern European polyclinics, which were secondary care hospital-based clinics, not set in the community. And there is a concern that the model would be to centralise general practice away from patients. "The connotations were the problem. A polyclinic doesn't have to be a new building. We're saying you can use existing buildings much more effectively; you could have a virtual extended service, or a health centre model where everyone isn't in the same building and they're working as one unit."

> "The idea of polyclinics has been going down like a lead balloon with most GPs"

But in inner city deprived areas, where general practice has suffered from under-investment, there may be grounds to have new buildings in place, he says. "General practice is a local, bottom-up service, as community pharmacy is, and sometimes you may have to house people in a slightly bigger centre because of the poor premises. But to remove people from especially socially deprived communities goes against the traditions of general practice and community pharmacy and isn't a service to patients."

In these situations though, contractors are concerned that a pharmacy in the polyclinic centre will take all the local business. And if GP practices disappear, those near to the old sites will suffer.

Dr Colin-Thomé says he has "no easy answers. With competition you either roll over and lose, or proactively manage it. So if there's a valid fear that someone will come in and take your trade, shouldn't you be thinking how you can get the good relationships so that that person could be you?"

So are there tough times ahead for pharmacy? Even Dr Colin-Thomé admits that they are likely to be interesting.

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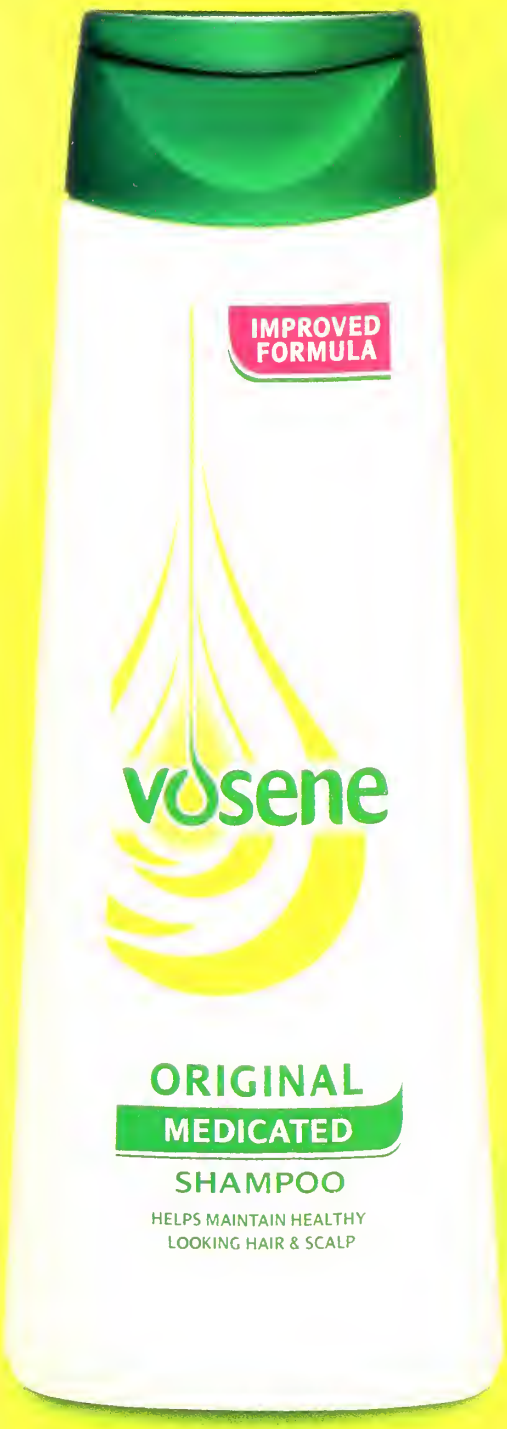

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Please don't take my certificate away

I have made my most significant contribution to the formation of a new professional body so far by completing the Opinion Leader questionnaire I received in the post. It was much less demanding than submitting evidence to the Clarke Inquiry, and gave me some clues as to what the Royal Society of Pharmacy might get up to.

The main problem the new body will have is getting people to join. As membership will be optional, there must be a pretty strong case for persuading people to put their hand in their pocket. This questionnaire seems to be designed to tease out how to make this case as strong as possible, if not irrefutable.

I'm pleased that I'm being asked what I would like from a new professional body, but concerned that if it becomes unbearably difficult to carry on working without membership, I will feel blackmailed into joining. I'm selfish enough not to feel compelled to pay for the Society's 'voice of the profession' role, even if it is ultimately in my interest. But if it is providing essential help with revalidation, for example, I may feel forced into opening my wallet.

This questionnaire even threatens to take away my professional identity by removing my right to use MRPharmS after my name if I don't sign up. Obviously I shouldn't falsely pretend to be a member of the Society, but if I became a simple BPharm or BSc, how would anyone know I was a registered pharmacist rather than simply a pharmacy graduate?

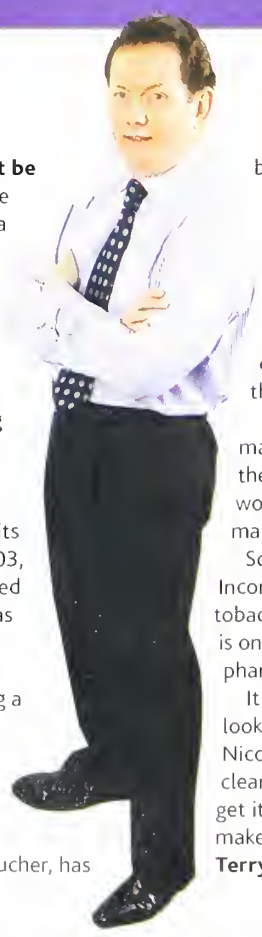
I wonder if they would send someone round to my pharmacy to remove my certificate from the wall if I didn't pay up, or whether I could keep it as a souvenir. To replace my hard earned and beautiful certificate with a functional looking document from the GPhC would be a shame indeed. And Anne would be distraught if she lost her technician's registration certificate.

At the end of the day it comes down to money and the Society Mark 2 will want to charge as much as it can without putting people off. A significant majority of pharmacists recently demonstrated that they think 400 quid is too much already. But the questionnaire suggested that combined membership of GPhC and RSP would be more than this, possibly much more.

For the small amount of money I would like to pay for membership, the RSP wouldn't be able to deliver very much at all. That's the Catch 22 the Society is facing. Pharmacists are a tight fisted bunch and I don't think they'll pay very much for the privilege of some letters after their name and a weekly magazine. Forcing them to join could be counter-productive.

I've taken my certificate off the wall and hidden it. Just in case.

Scum and Silk



Scum may not be your ideal customers but you might be encouraged to change your mind when you considered the principles of social marketing. Silk, if your pharmacy is in a socially deprived area, will make up a big chunk of your existing customer base and together Scum and Silk deserve your attention because they can make you money while you make a difference to public health, or something like that.

That I think was the message from a presentation on social marketing given at the Annual Seminar for Smoking Cessation Providers in Antrim recently. The presentation suggested that the health service has finally woken up to the benefits of marketing in directing social change. The Northern Ireland Smoking Cessation Service (NISCS) has its origins in Smoking Kills monies and when this dried in 2003, National Opportunity Funding from the Big Lottery allowed the services to be continued and expanded. The service has been a success and now attracts recurrent funding from central government.

It's pleasing to see that community pharmacy is playing a key role in this service and many seminar delegates were pharmacists, which wasn't bad considering that other delegates were there as part of their day job and did not get to pay the locum fee.

The pharmacy part of the NISCS, introduced at the end of 2006 and permitting pharmacists to supply NRT on voucher, has been a huge success. In 2007 about one-third of all smokers enrolled into the NISCS did so through community pharmacy and our success rate at four weeks was over 54 per cent, higher han the figure for GP, nurse or voluntary sector-led services.

But smoking remains the most important public health problem our health service faces and with 350,000 smokers in Northern Ireland, all agencies must do more to reduce the impact of tobacco on health. Even though 20,000 smokers made a quit attempt on the scheme last year, this represents only 5 per cent of all smokers.

How do we target the hard-to-get-at groups? Use social marketing, stupid. Better targeting of problem groups, motivating them to think about stopping and then supporting them to stop would make a big impact. This is where Scum, Silk and social marketing come in.

Scum stands for Self-Centred Urban Male and Silk stands for Single Income Loads of Kids. These are the hard-to-get-at market segments in tobacco control. Silks have a smoking prevalence of 54 per cent and this is one of the key reasons for social inequalities in health; GPs and pharmacists have a 10 per cent smoking prevalence.

It is my prediction that in 100 years the society that exists then will look back at our tobacco smoking habit with amusement and wonder. Nicotine might still be used as a recreational drug but it will be in a clean pharmaceutical form that will avoid the need to burn tobacco to get its CNS effect. Until then, community pharmacy is well placed to make an impact on the smoking numbers.

Terry Maguire is a community pharmacist in Northern Ireland

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MUR trouble than they're worth?

Medicines use reviews (MURs) are without doubt the biggest innovation, and the biggest change, in community pharmacy in at least 50 years but neither Sam Webb nor John D'Arcy gives any indication in your article (C+D, March 29, p12), that they have realised the exact extent of the change.

The primary function of any pharmacist is to ensure that patients come to no harm and this primary function is buttressed and delineated by a wealth of legislation.

As far as the community is concerned, the important legislation is that which says the pharmacist in charge of a community pharmacy must personally supervise all sales of Pharmacy (P) medicines and must personally supervise all dispensing – and the circumstances of that supervision have been set out in a series of judgements in a variety of cases.

It seems unlikely that these onerous responsibilities under the law will be altered at any time in the near future. Pharmacists themselves are quite clear that they carry a heavy personal responsibility and can be sued by patients for large amounts of money, a fact which appears sometimes to escape the attention of their employers.

Now we can all agree that conducting an effective MUR must involve the pharmacist in a private face-to-face interview with the patient and it seems to be normal for any effective interview to take about 20 minutes, during which time the pharmacist can have no part in the running of the remainder of the operation.

> The primary function of any pharmacist is to ensure that patients come to no harm

Bearing the law in mind, it is difficult to see how P medicines can be sold, or prescriptions handed out, while the pharmacist is conducting an MUR. This is a fundamental difficulty that can only be solved by co-operation and, perhaps, a change in the law.

There seem to be no proposals for the pharmacist's personal responsibilities to be lessened. Indeed, on reading, the present consultation on the responsible pharmacist may lead to an increase in those responsibilities. Squaring this circle may call for more ingenuity than we collectively possess.

The advent of accredited checking technicians (ACTs) will be no help since responsibility will remain with the pharmacist who may still be struck off if a disaster occurs. The position of locums seems likely to be the most difficult, since how can they rely on ACTs who they do not know?

Underlying all these difficulties is the simple fact that the average pharmacy dispensing 6,000 items per month in an eight and a half hour day, five days a week, is dispensing one prescription item every two minutes, which leaves little time for other work. It is notorious that a good proportion of pharmacy managers work for quite a lot longer than their contracted hours in attempts to get through their work. That they do this for the benefit of patients is praiseworthy, that they do it for the financial gain of their employers without personal reward is reprehensible. Little wonder that there is an ever-present shortage of pharmacists prepared to work in the community under the conditions and for the rewards on offer.

Yet immense and increasing pressures are being put on pharmacists to carry out increasing numbers of MURs. Some have been threatened with disciplinary action if they do not reach their quotas. Now there is no doubt that contractors accepted a very poor deal over the new contract, but only a cynic would remark that pharmacy owners are now attempting to mitigate their self-imposed losses at the expense of their workforce.

Such pressures and declarations that "all jobs change and develop" neglect the fact that change today needs to be by mutual agreement, not by imposition. With respect, John D'Arcy may feel that "MURs are now part and parcel of a pharmacist's job," but this can only be the case if pharmacist employees agree with him. Such changes can no longer be imposed in an old-fashioned way and it is quite plain from the low take-ups of MURs that the large majority of pharmacists agree with this.

Already a number of pharmacist managers have left their jobs because of pressures to carry out MURs and it may be that at least some of these have arguable cases for compensation for constructive dismissal if the content of their job has been changed without their agreement and they have been unable to live with these changes. Their chances of compensation will naturally be enhanced if in that change of job conditions there has been an element of bullying by intermediate management, unbeknownst, of course, to senior management.

So, while MURs are perhaps the most exciting and important development in community pharmacy for a very long time, like all change they need to be introduced by negotiation and agreement, underpinned by a clear basis in pharmacy law. Working together we can all look forward to a golden future for pharmacy.

Bob Gartside FRPharmS, Llanberis, Gwynedd

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Luck of the draw on dispensing errors?

When I was collating a response from the Pharmacy Law and Ethics Association (PLEA) to the latest consultation[1] on how the RPSGB should deal with dispensing errors, a hospital colleague said: "Are you saying that a single dispensing error in community [pharmacy] could really result in disciplinary action? Why doesn't this happen in hospital?"

Isn't it time we examined afresh the whole rationale for enforcement of disciplinary norms in community pharmacy? In truth they were designed for shopkeepers in trade and the perceived need to protect the public from substandard and adulterated medicines. To what extent are they "fit for purpose" for the clinical professionals and activities in a "modernised" community pharmacy?

Supplies of medicines "carried out in the course of the business of a hospital" fall outside the scope of the Medicines Act. This means the Society's inspectors have no power to inspect error records or to investigate complaints relating to hospital practice. Contrast this with community pharmacy. Not only does the Society investigate every dispensing error passed to it but it is still a criminal offence to make a dispensing error. So there are likely to be glaring differences in the way hospital and community pharmacists feel about recording and reporting dispensing errors.

The likelihood of investigation is random. It is only if a patient (or primary care organisation) complains directly that the Society will be alerted. But many mistakes are settled on the spot; compensation cases are settled out of court; Coroner's court verdicts make the local press but there is no consistent referral process to professional discipline if those affected choose not to pursue it.

There is no logic to several of the proposed criteria for referral to formal discipline. Serious failures of dispensing practice may, in fact, lead to no harm. Momentary lapses, to which all of us are prey, can lead to a fatal outcome. The referral criterion of "relevant history within the last three years" is neither objective nor rational. We really have no idea what frequency of errors is either acceptable or "normal". Moreover, we know errors arise at least as often from environmental conditions in the pharmacy as from impaired practice on the part of a pharmacist. So perhaps the parameters of the pharmacy – its ownership, location, names of staff and superintendent – should be included in the three-year history. And where is the justice in retaining warnings on a pharmacist's file forever? What happened to rehabilitation?

With the General Pharmaceutical Council waiting in the wings, these flaws should not be passed on 'wholesale' to the regulator without a radical examination of the criteria's rationality, consistency and ability to protect the public *and* deal with a*ll* pharmacists fairly.

A new professional body, if we are lucky enough to get one, should be working tirelessly and positively to help pharmacists tackle the conditions that can cause dispensing errors and encourage the regulator to do likewise.

Professor Joy Wingfield, chairman, PLEA

1. The Pharmacy Law and Ethics Association: Response to the consultation on referral criteria for the Investigating Committee.

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C+D Clinical

Insect bites and stings

With summer on the way, C+D looks at the aetiology and management of common bites and stings

Key points

- There is not usually an immediate reaction to an insect bite, unless the individual bitten is hypersensitive.
- Malaria must be considered in people who have recently returned from abroad who have influenza-like symptoms.
- Bee and wasps stings can cause anaphylaxis. Susceptible individuals should carry adrenaline auto-injector pens.
- There is little useful treatment for jellyfish stings, other than waiting for the pain to subside.
- There are many OTC products for bites and stings, but use is limited by a lack of supporting evidence or licensing restrictions.

Alan Nathan

The incidence of insect bites and stings is unknown. They are more common in the summer when people spend more time outdoors, but some biting insects live inside people's homes and are a hazard throughout the year.

The pathopharmacology and effects of bites and stings differ, but treatment for both is more or less the same. Treatments for all but the most serious reactions are available without prescription.

Insect bites

Insects usually bite in order to gain access to the victim's blood supply to feed on it. The skin is punctured and the insect's saliva is secreted into the dermis.

The saliva usually contains enzymes or other agents to liquefy the blood to facilitate its flow back through the insect's

The College of Pharmacy Practice

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Reflect

Could you list the characteristic symptoms of malaria? What does a bed bug bite look like? What is the best treatment for a jellyfish sting? Could you name three constituents of wasp stings?

Plan

This article describes the OTC treatment of bites and stings of common insects and jellyfish and possible future methods of delivering drugs through the skin.

CPD This article can help in the following CPD competencies: **G1a, G1c, C1a, C1f, C1g, C2a.** See www.tinyurl.com/264zu

Jellyfish tentacles are covered with batteries of specialised stinging cells. Detached tentacles found on the beach remain capable of stinging for several weeks

Photo: Morguefile

feeding apparatus. It may also contain a local anaesthetic so the bite is undetected by the victim, allowing the insect to feed undisturbed.

The bite itself causes little injury, and lesions occur as a result of the immune response to the antigens introduced. The time course of the reaction depends on the immune mechanism involved. A bite can also introduce infection into the skin.

Allergic reaction to bites

There is usually no immediate reaction to a single bite, unless a person is hypersensitive when an immediate urticarial wheal is produced.

Several bites at once or in quick succession produce a similar reaction. A firm pruritic papule usually develops over about 24 hours. Delayed pruritic papules, nodules and vesicles that develop within 48 hours following the bite, are manifestations of a delayed hypersensitivity reaction to antigens introduced during the bite.

Allergic reactions to bites of some insects, eg head lice, take several weeks to develop. Continual or repeated exposure to bites generally results in eventual desensitisation, with further bites causing little or no reaction.

In atopic individuals, particularly young children, papular urticaria can occur as a result of bites or mere contact with sensitising insects or their body products. In this condition, crops of itchy red papules up to 2cm in diameter, which may develop into a fluid-filled blister, appear every few days during the summer or autumn. They occur most frequently on the legs and other uncovered areas such as forearms and face, but may be scattered in small groups all over the body.

Common biting insects

Midges, gnats, mosquitoes: small, itchy, papular lesions; wheals and bullae in sensitised individuals.
Fleas from dogs, cats and other domestic pets: small itchy papules grouped in lines or in irregular clusters, often on ankle and lower leg; occasionally papular urticaria and bullae in sensitised individuals.
Bedbugs: often do not cause sensitisation, only a purpuric macule at the bite site; sensitised individuals characteristically develop intensely irritating wheals or papules surmounted by haemorrhagic puncta; they occur anywhere on the body, but often on the face; lesions often occur in linear groups of three.
Horse flies: cutaneous wheals, often painful; may also be urticaria, dizziness, weakness, wheezing, or angio-oedema; secondary infection is common.

Glossary of terms

Angio-oedema: a manifestation of allergy, characterised by patches of circumscribed swelling of the skin.
Bulla (pl.bullae): a large vesicle or blister.
Erythema: redness.
Haemorrhagic: blood filled.
Indurated: having become firm or hard.
Papule: a small, solid, usually conical elevation of the skin caused by inflammation, accumulated secretion, or hypertrophy of tissue.
Pruritus: itching.
Punctum (pl. puncta): a small area marked off from the surrounding surface.
Urticaria: a rash produced by release of histamine in the skin, characterised by itching, redness and whealing.
Vesicle: an abnormal elevation of the outer layer of skin enclosing a watery liquid.
Wheal: a suddenly formed elevation of the skin surface.

Malaria

Malaria is a common and potentially fatal disease transmitted by mosquitoes in tropical areas. It has long been eradicated from the UK, but each year about 2,000 people return infected from endemic areas. The initial symptoms are non-specific and resemble those of influenza.

Pharmacists have an important role in identifying suspected cases and referring patients for investigation, so be alert for symptoms of febrile illness occurring any time after the first week of possible exposure and for up to a year after return from a malarial area. These include raised temperature, headache, muscle ache, vague abdominal discomfort, lassitude and lethargy, appetite loss.

Pharmacists should strongly recommend prophylaxis to anyone planning to visit a malarial zone, and also advise travellers to take measures to avoid being bitten including the following:
- apply insect repellent to skin
- apply insecticide to clothing
- use knockdown spray or insecticide-impregnated mats to clear rooms of mosquitoes
- minimise exposed skin
- sleep under insecticide-impregnated mosquito netting
- wear light-coloured clothing.

Bee and wasp stings

Insect stings are primarily weapons, either of attack when used to incapacitate prey or of defence when a threat is perceived; their effect is intended to be immediate. The stinging apparatus of bees and wasps consists of a sac of venom attached to a stinger. Once the stinger has pierced the skin, the insect's abdomen contracts to compress the sac and the venom is deposited in the victim's tissue.

The pain and inflammation of a bee or wasp sting is caused by the direct pharmacological effects of its constituents, including:
- histamine and other biogenic amines
- haemolytic polypeptides, including melittin
- apamin, which is neurotoxic
- mast cell degranulating peptide, which causes further release of histamine
- enzymes including hyaluronidase and phospholipase, which break down intercellular tissue cement and assist penetration of venom.

After stinging, wasps extract the stinger from the victim, but a bee's stinger is barbed and is torn off as it pulls away and is left in the wound. The bee dies as a result but the sting stays connected to the venom sac, which continues to pump venom into the wound for up to a minute from the time of insertion. Bee stings should therefore be removed as quickly as possible, by gently scraping away with a fingernail.

The result is intense, burning pain followed by erythema and a small area (up to 1cm) of oedema, which usually subsides within a few hours. In sensitive individuals there may be a systemic allergic reaction severe enough to cause anaphylactic shock. Patients with known hypersensitivity usually carry an auto-injector pen containing adrenaline one in 1,000 (1mg/ml) for emergency use. There is an exemption to the legal restrictions controlling the supply and administration of medicines allowing adrenaline injection one in 1,000 to be administered by anyone for the purpose of saving life in an emergency.

Jellyfish stings

More than 100 jellyfish species are toxic to humans, although only a few of these are found around British shores. Jellyfish tentacles are covered with batteries of specialised stinging cells termed nematocytes. Each contains a nematocyst, the stinging apparatus, consisting of a poison sac with an attached sharp hollow tube armed with barbs. Mechanical and chemical stimulation of sensory hairs on nematocytes trigger the stinging process, and nematocysts are fired at high pressure into a victim's tissues, forcing them up to about 1mm into the skin.

Jellyfish toxins can contain catecholamines, vasoactive amines (eg histamine, serotonin), kinins, collagenases, hyaluronidases, proteases, phospholipases,

fibrinolysins and, in the more dangerous species, dermatoneurotoxins, cardiotoxins, neurotoxins, nephrotoxins, myotoxins, and antigenic proteins. Detached tentacles left on the beach pose a hazard as they remain capable of stinging for several weeks.

Immediate acute reactions to the venom tend to be toxic rather than allergic and include tenderness, burning, and pruritus, with local soft tissue oedema and angio-oedema. Erythematous papules and blisters occur in a whiplike pattern and can take several weeks to fade away.

Treatment is limited. The affected area should not be rubbed as this forces venom further into the skin and spreads it. Applying vinegar or ammonia followed by hot water is thought to be helpful, otherwise there is little that can be done except wait for the pain to subside.

Treatments

Preparations marketed for the treatment of bites and stings are generally intended to suppress cutaneous sensory receptors, and contain antihistamines, local anaesthetics, astringents and soothing constituents. Hydrocortisone is also licensed for the treatment of insect bites.

Antihistamines Histamine is one of the main mediators of the inflammatory response to bites and is also a principal component of insect stings, so treatment with antihistamines would seem logical. Several topical products containing antihistamines are licensed for treating the pain, itching and inflammation associated with bites and stings. However, topical antihistamines have been criticised as not being very effective, and they are also liable to cause sensitisation so they should not be used more often than two or three times a day for a maximum of three days. Oral antihistamines are more likely than topical preparations to bring sustained and effective relief. Non-sedating compounds are preferable; they are as effective as the older antihistamines for peripherally-mediated reactions but are not associated with central sedating and antimuscarinic side effects.

Local anaesthetics The effectiveness of local anaesthetics in the treatment of bites and stings is debatable. Sensitisation on prolonged usage is also an acknowledged problem and licensing restrictions on the length of use take account of this. Spray formulations may be more effective than creams or lotions as they contain higher concentrations of local anaesthetic. They are likely to be most useful straight after a bite or sting because they produce relief, although short-lived, when the pain is most intense. The cooling effect produced by the evaporation of the propellant contributes to the pain relief.

Hydrocortisone This has anti-inflammatory activity and hydrocortisone cream 1 per cent is licensed to treat itching caused by insect bites. However, its usefulness may be limited by the licensing restriction of two applications daily, as more frequent application may be necessary to sustain relief. It is not licensed for use in children under 10 years of age.

Calamine and zinc oxide Calamine is a naturally occurring basic zinc carbonate with ferric oxide, which imparts the characteristic pink colour. It is mildly astringent and its soothing antipruritic action is due to the large surface area and porous nature of its particles, which promote the evaporation of water from calamine preparations, with a consequent cooling effect. Calamine Lotion BP also contains 0.5 per cent phenol as a preservative, which has a local anaesthetic action. Calamine has been used for generations for treating urticaria and pruritus from many causes, including insect bites. It is cheap and there are few restrictions on its use. Zinc oxide has similar properties.

Crotamiton This has antipruritic properties and can be used topically for bites and stings. It is claimed to have a prolonged action of six to 10 hours after application.

Ammonia solution This has been claimed to have a neutralising effect on bites and stings, but there is little or no objective evidence of its effectiveness except, perhaps, for jellyfish stings.

Alan Nathan FRPharmS is a pharmacy writer and consultant and visiting lecturer at King's College, London. Some of the information in this article is based on material in his book, Non-prescription Medicines (3rd edition), published by the Pharmaceutical Press.

Your Continuing Professional Development CPD

• Familiarise yourself with the first aid treatment of anaphylaxis. Would you recognise the signs and know when to call an ambulance? Make sure you know how auto-injectors are used and the recommended dose, so you could inject someone or help them self-inject in an emergency.
• Could you supply (or suggest a stockist for) all the items, such as mosquito netting, listed in the article as being recommended for travellers to malarious areas?
• Read the information about identifying bites and stings on http://cks.library.nhs.uk/insect_bites_and_stings/in_depth/background_information.
• Be aware of the types of insects most likely to be responsible for bites/stings in your area and make sure you know what the bites might look like. Pictures of stinging insects can be seen at http://www.traveldoctor.co.uk/stings.htm.
• Are you likely to see cases of tick bites? If so, what are the symptoms of Lyme disease?

• Are you now more able to recognise insect bites and stings and recommend suitable treatments? Could you cope if someone was having breathing difficulties after being stung by a bee?

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the June 7 issue, which will cover this month's three CPP-accredited modules.
A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

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VP101	Calcium with Vitamin D	400mg	~~30s~~ 40s	Tabs	6	£3.54	£0.99
VP040	Multi Vitamins & Iron	OAD	~~60s~~ 80s	Tabs	6	£3.54	£0.99
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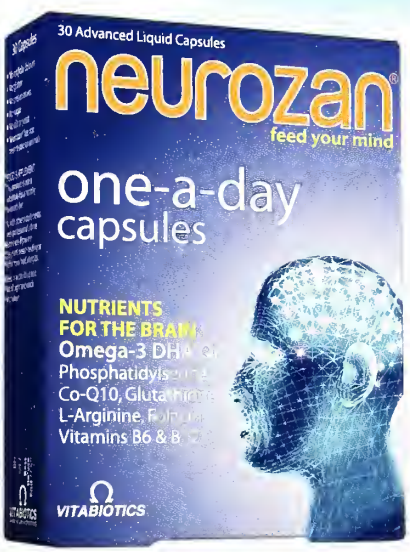

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VITABIOTICS

New press & outdoor advertising campaign this summer

Clinical Alerts

MHRA Alerts

Clexane injection (enoxaparin) Some batches contain low levels of an impurity, though there is no evidence that this is associated with any risk to the patient. No batches are being withdrawn but, as a precaution, intravenous and arterial administration should be avoided. Contact Sanofi-Aventis for more information, tel: 0800 281973.

New Products

Niddaryl tablets 30s (glimepiride) Indicated for type 2 diabetes, where diet, exercise and weight reduction are insufficient. Available in 1mg, 2mg, 3mg and 4mg strengths. Dee Pharmaceuticals, tel: 01978 661993.

Plavix 300mg tablets 30s (clopidogrel) New strength. Sanofi-Aventis, tel: 01483 505515.

Salbulin 100mcg Novolizer refillable device and refill 200 metered doses (salbutamol) Meda Pharma, tel: 08454 600000.

Study finds alendronate may have atrial fibrillation link

Osteoporosis treatment alendronate may be associated with an unexpected increase in atrial fibrillation, the authors of a study have concluded.

They calculated that 3 per cent of new atrial fibrillation cases in the women studied may have been attributable to alendronate treatment.

The trial subjects were aged from 30 to 84 years old.

The authors suggested that atrial fibrillation in patients taking alendronate may be due to a range of factors, including disrupted functioning of regulatory proteins, inflammation, or small reductions in blood calcium and phosphate levels.

The benefits of fracture prevention in patients at high risk for fracture will generally outweigh the possible risks of atrial fibrillation, the authors argued.

However, the benefits should be weighed carefully in patients with only modestly increased risk of fracture, or who have risk factors for atrial fibrillation. Arch Intern Med 2008; 168: 826–31.

Clinical News – sign up for C+D's clinical newsletter at chemistanddruggist.co.uk/register

No to abatacept appeal

Nice has rejected an appeal against its earlier decision not to recommend abatacept (Orencia) for treating severe rheumatoid arthritis. The National Rheumatoid Arthritis Society said that it was bitterly disappointed by the decision as the treatment would only have been continued in patients who did benefit.

Nice advice on abatacept: http://tinyurl.com/4l24f2
NRAS statement: http://tinyurl.com/5td72o

HPV vaccine takeup good

Uptake has been "encouraging" in a pilot trial of human papilloma virus vaccine among adolescent girls at 36 schools in Manchester. For the full story go to: www.chemistanddruggist.co.uk/clinical

SSRI switch may be right

Patients who fail on one SSRI are more likely to benefit from a non-SSRI second-line treatment, a meta analysis of four studies has concluded. For the full story go to: www.chemistanddruggist.co.uk/clinical

A Practical Approach

Refractory hypertension

David Spencer, pharmacist at Update Pharmacy, receives a phone call from local GP Mo Merali.

"David, I've got a patient who is also a repeat dispensing patient of yours. I'm a bit concerned about him and wondered if you could have a word? He's on his way to you now with his next repeat script."

"Of course. What's the problem?" David asks.

"It's Evan Normans, he's 64 years old. He first came to me a couple of years ago suffering from work-related stress. His BP was nearly 200/120, so I sent him for tests, but everything – heart, renal function – was completely normal. I recently added amlodipine to his bendroflumethiazide and lisinopril, but he's still around 165/100. I wanted to get him to have a 24-hour ambulatory BP check, but he said he didn't want to go to the hospital to have the monitor fitted. And he seems very nervous and uncommunicative when he comes to see me. I feel there's another issue he won't tell me about."

"I always get on fine with Mr Normans, I'll speak to him when he comes in," David replies.

David Farram

When Mr Normans comes to the pharmacy David manages to get him to explain his problem.

"It all goes back to when I was a child," Mr Normans says. "I was always ill and was in hospital quite a lot. The staff weren't very nice to me and it's left me absolutely terrified of doctors, nurses and hospitals."

Questions

1. Could Mr Normans' past have anything to do with his high blood pressure?
2. What could David do to help?

This article can help in the following CPD competencies: **G1a, G1b, G1d, G1e, G1s, C1c, C2a, C3e .** See www.tinyurl.com/194zu

Answers

1. Yes. He is probably suffering from 'white coat hypertension': BP raised by fear and anxiety about the thought or presence of medical staff, but likely to be lower normally.

2. He should ensure that Mr Normans is taking his medicines as prescribed and that he is not taking any other drugs, such as NSAIDs and steroids, that might interfere with BP control, by carrying out an MUR.

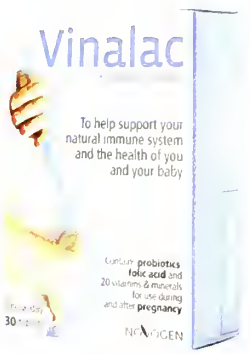
He could also suggest that Mr Normans monitors his own blood pressure at home to get a truer value. He should take triplicate readings night and morning for three days. The equipment should first be validated as accurate.

He could also suggest that Mr Normans has cognitive behavioural therapy, if he will accept it, to address and overcome his phobia.

And he could give lifestyle advice, including losing weight, taking exercise, and reducing salt and alcohol intakes, which can all contribute to lowering BP

Probiotic boon

Vinalac is a new probiotic formula to be taken by pregnant and breastfeeding women. Containing *Lactobacillus rhamnosus*, 400mcg folic acid and 20 other vitamins and minerals, the product is said to support the mother's immune system and benefit the long-term health of the baby.



Clinical studies have shown frequency of allergic eczema is reduced by almost half among children from mothers with a family history of allergy who have taken *Lactobacillus rhamnosus* compared with those taking a placebo.

Vinalac will be supported by a £500,000 marketing campaign to include PR, advertising and trade promotions.

Price and Pip code: £12.99/30; 334-4678
Novogen
Tel: 0845 603 1021

Going fourth

GUM PerioBalance is a probiotic lozenge launched by Sunstar. It is positioned as the fourth step to add to GUM's current three step approach to oralcare.

Said to reduce plaque build-up and reduce gum bleeding and inflammation, PerioBalance restores the natural balance of the mouth, says manufacturer Sunstar.

Each mint-flavoured lozenge contains at least 200 milllion active *Lactobacillus reuteri Prodentis* bacteria at the time of manufacture.

The product is backed up by clinical studies that have shown regular consumption can help increase levels of friendly bacteria.

Price: £15/30
Trinity Sales & Marketing
Tel: 01235 838590

Syndol gets TV treatment

Tension headache treatment Syndol will be back on television this month in a campaign breaking on May 19. Running at peak times until June 22 on ITV, GMTV, Channel 4, Channel 5, S4C and satellite channels, the ad shows a man with a tension headache in an office setting. A woman offers him a pill with a massage in a seductive manner – then shows him a pack of Syndol for pain relief with added 'aaahhhh', says manufacturer SSL.

The campaign is expected to boost sales by more than 10 per cent, predicts the company.

Product info:
SSL International
Tel: 08701 222689

Follow Foster Grant's trend

A new range of ready-to-wear reading glasses has been unveiled by Foster Grant. The 2008 collection is said to reflect the latest eyewear trends and includes a choice of frame materials spanning aluminium, titanium, plastic and wood.

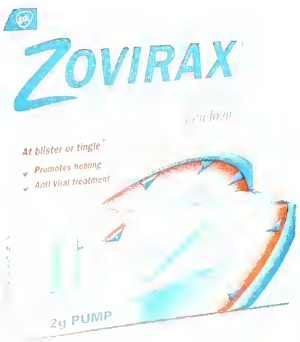
Key features include spring temples, floating lenses and adjustable nose pads. All styles use lightweight lenses with anti-scratch coatings. The selection of lens strengths starts at +1.00, says the company.

Also new is a range of bifocal sun readers, targeting the outdoor and holiday market. With a dioptre on the bottom half of the lens, the glasses are available in four strengths and offer full UV protection.

Point of sale materials are available. Display stands feature a simple self-test eye chart.

Price: up to £14.99
FGX Europe
Tel: 01782 813000
customerservices@fgxe.co.uk

Time for a change



A new pack design has been unveiled for Zovirax cold sore cream from GSK. The focus is on the familiar clock graphic with the key message that the cream is effective at the blister and tingle stages of a cold sore. Text emphasises its antiviral activity and ability to promote healing.

Zovirax contains acyclovir with propylene glycol to aid penetration. It should be applied five times daily for four days. GSK hopes the new look will reinforce the brand as the leading cold sore cream (source: AC Nielsen, w/e Jan 26, 2008).

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Retail TALK

Have you made your first OTC sale of Feminax Ultra?

WEB VERDICT:

Yes: 14%
No: 86%

Off the shelf view: It looks like a slow start for sales of Feminax Ultra. Of course it's early days but our next poll aims to shed light on the reasons. Could it be a lack of customer demand? Insufficient training to feel confident selling the product? Or none in stock?

Vote at **www.chemistanddruggist.co.uk/prodnews**

For on TV this week see:
www.chemistanddruggist.co.uk

summerhealth08

any allergy questions?

Summer health

We're entering the holiday season and your customers will be making preparations to go away. Over the next seven pages, C+D brings you up to speed with the best advice on subjects such as allergies, sun protection and travel sickness, plus products you should be stocking to maximise sales opportunities of these seasonal products.

Q **A staff member tells you the customer at the counter wants to buy "excessive" quantities of pseudoephedrine; what do you do?**

A You must interview the customer. Looking at the worst case scenario, this could be a potential sale of a precursor chemical used in the illicit production of methamphetamine, but is it likely? Do you know the customer, is he/she one of your regulars? If in any doubt, the course of action is clear. You must veto the supply. More likely is the case of a family going away, unaware of the new restrictions. A few enquiries about the intended use and a sensitive explanation about your sales being restricted to the new governmental limits will suffice.

Q **What do you say to your technician who has concerns over the drowsiness warning on their antihistamine tablets?**

A Explain the differences between the older and newer generation antihistamines. Chlorpheniramine and promethazine both have great value in symptom suppression, but they may cause drowsiness. They also may interact unpredictably with alcohol. The second generation antihistamines are more expensive but equally effective. Give the detail and let the technician make an informed choice.

Pseudoephedrine and ephedrine reminder

Meth Guard

Pharmacists have received a lot of guidance and advice on selling products containing these drugs and the recent changes in the law. From April 1 it became unlawful to sell or supply a product or products containing more than 720mg of pseudoephedrine or more than 180mg ephedrine to a person at one time (ie in one transaction) without a prescription. Pharmacies should also not sell or supply a pseudoephedrine product at the same time as an ephedrine product in one transaction.

Commonly found in cough and cold products, the drugs are in the spotlight during the winter months but should not be forgotten in summer. An MHRA spokesperson explained: "It is important to remember that these drugs are also present in some hayfever and allergy medicines. Their sale is therefore not confined to the winter months, and pharmacists should continue to be vigilant about the sale of these drugs throughout the year."

Once you have familiarised yourself with the new rules, it's worth checking for products containing the drugs (see right) and informing your staff. Those not following the law will be committing an offence under the Medicines Act and could face a fine or even imprisonment.

The action was taken because pseudoephedrine and ephedrine can be used to manufacture the drug methylamphetamine (crystal meth).

Pharmacists and their staff must look out for requests for large quantities or for frequent requests, and should refuse to provide the medicines where there are reasonable grounds for suspecting misuse.

Training is available from a variety of sources, including C+D's Methguard training scheme – www.chemistanddruggist.co.uk/stafftraining

Product checklist

The products below, containing ephedrine or pseudoephedrine, are all indicated for relief of allergy or hayfever symptoms.

Actifed Multi-Action Syrup – contains pseudoephedrine HCl 30mg/5ml

Actifed Multi-Action Tablets – contain pseudoephedrine 60mg/tablet

Benadryl Plus Capsules – contain pseudoephedrine HCl 60mg/capsule

Haymine tablets – contain 15mg ephedrine/tablet

Sudafed non-drowsy decongestant elixir – contains pseudoephedrine HCl 30mg/5ml

Sudafed non-drowsy decongestant tablets – contain pseudoephedrine HCl 60mg/tablet

Jeremy Clitherow FRPharmS offers a timely reminder of the queries, questions and quandaries allergy sufferers commonly raise

Q **A teenager sitting GCSEs needs to be alert but his runny nose makes concentration impossible; what's best?**

A If this young man's allergy is protracted, and he wants a full season therapy, he should avoid the sedating first generation antihistamines and use either one of the newer non-sedating ones or possibly move to dampening down his allergic reaction with a steroid nasal spray or even to stabilise his mast cells with cromoglycate. However, if his allergy is only troublesome occasionally, he might think of using an antihistaminic nasal decongestant spray, intermittently though, and beware of triggering rebound nasal congestion.

Q **The patient is pregnant; what is safe for hayfever?**

A Current best advice is still that all medication carries a risk to a developing foetus, particularly in the first trimester, so be guided by the GP. Avoidance of contact with pollen and barrier protection against the airborne allergens has to be the counsel of perfection.

Q **What do you say to a customer who has recently purchased a nasal steroid spray and is worried by news reports of an athlete being banned for life for using 'steroids'?**

A Offer reassurance and explain the differences between anabolic steroids and corticosteroid anti-inflammatories, then check for understanding by asking a targeted open question afterwards, and rephrase your explanation if necessary.

For more allergy Q&As visit www.chemistanddruggist.co.uk/summerhealth

Allergy product news

There's only one Piriton

Piriton allergy tablets are being supported with a £3.6 million marketing budget, reports manufacturer GSK. Promotional activity will include TV, national press and outdoor advertising.

The two 20-second television ads, first seen last year, focus on bizarre allergies. They close with the strapline 'Millions of allergies. Only one Piriton' and are backed up by sponsorship of GMTV's pollen count and allergy week.

Press advertising is running in women's titles while the parenting press will carry Piriton syrup ads.

A 60-tablet, pharmacy-only pack of Piriton was launched this year and Piriteze allergy tablets have been licensed for use in children aged six and over.

GlaxoSmithKline Consumer Healthcare; tel: 0845 762 6637

Optrex tells eyes' true story

TV advertising for Optrex is underway. Expected to reach more than 30 million people this summer, the campaign relays the message that many factors cause eyes to feel tired and sore, such as computer use, air conditioning and lack of sleep.

Everyday scenarios are used to convey the 'eyes tell the true story' concept, with Optrex refreshing eye drops shown as the solution to regaining beautiful eyes.

New to the range this year is Optrex Itchy Eye drops (£3.99/10ml). Suitable for relieving irritation caused by pollen, it should be sited alongside other seasonal products such as antihistamines, suggests RB.

The drops contain witch hazel to soothe and refresh eyes and, once opened, last 28 days.

Reckitt Benckiser; tel: 01482 326151

Zirtek's hayfever answer

The Zirtek brand is to receive an advertising boost to coincide with the hayfever season. Shoppers will be targeted at the point of sale via Pharmasite media, and a national magazine advertising campaign will benefit from a budget increase of 45 per cent over the key period.

The Zirtek range includes tablets, a solution, and a sugar-free banana-flavoured solution that can be used for children aged two years and over.

Each Zirtek dose is designed to relieve hayfever symptoms, such as itchy eyes and a blocked nose, for 24 hours. The range can also be used for other common conditions such as dust or pet allergies.

UCB Pharma; tel: 01753 534655

Benadryl's speedy message

Benadryl is being supported with a £4 million advertising campaign this summer, covering television, press and internet advertising. Communications will focus primarily on Benadryl Allergy Relief (acrivastine), and will include the company's message that it "gets to work in 15 minutes".

The Benadryl allergy range further includes products for children, a one-a-day product and an oral syrup.

Manufacturer McNeil offers support for pharmacists through Allergy Training Modules.

McNeil; tel: 01628 821327

summerhealth08

Où sont les toilettes?

Travel is said to broaden the mind and loosen the bowels. But before the traveller's diarrhoea can kick in, there's travel sickness to overcome. **Lesley Ribbens** reports

Picture the scene. Against all the odds, the family has managed to get everything in the car and set off on time to catch their plane/train/ferry to sunnier climes. They're making good time when a voice pipes up from the back-seat: "I'm going to be sick!" Dad stops the car and their ETA, and the child's breakfast, go out the window.

More than half of children aged four to 16 suffer with travel sickness. While many grow out of it – or at least learn to manage the condition – it can still be troublesome for adults too. Coping strategies include:

By road: getting a clear view of the road; avoiding reading or looking down; keeping the vehicle cool and well ventilated; asking the driver to drive considerately and taking regular breaks.

By air: getting a seat over the wing and relaxing.

By boat: focusing on the horizon; going out on deck for fresh air; sitting in the middle of the vessel where movement is at a minimum.

Heavy meals should be avoided prior to and during travel. Motion sickness remedies work best when taken before the journey begins, but many cause drowsiness so drivers should be warned. Ginger or peppermint can be effective while acupressure wristbands are backed up by clinical trials.

Delhi belly

At the journey's end, thoughts may turn to traveller's diarrhoea. Contaminated food, cooked and raw, or water can be to blame, with the risk greatest in countries with poor hygiene. Tourists should be advised to lessen the risk of problems by avoiding street vendors and eating 'safe' food. Particularly risky options include raw or undercooked meat, poultry, seafood, raw fruit and vegetables. The safety of tapwater should be checked according to the destination. If in doubt, stick to purified water. Regular hand washing is another key line of defence.

In case problems are encountered, oral rehydration products should be recommended and, if appropriate, an antimotility treatment such as loperamide (check for contraindications). For those planning to travel to countries where traveller's diarrhoea is almost inevitable, getting a private prescription for antibiotics before travelling is an option.

There is some evidence to support the use of probiotics to prevent and treat traveller's diarrhoea. The theory is bacteria in the gut help protect the body from infection by colonising the whole mucous membrane of the intestine and preventing pathogenic bacteria gaining a foothold. Trials have found significant efficacy for the prevention of traveller's diarrhoea for several probiotics including *Saccharomyces boulardii* and a mixture of *Lactobacillus acidophilus* and *Bifidiobacterium* (Meta-analysis of probiotics for the prevention of traveller's diarrhoea, Lynne McFarland, 1st International Conference of the Journal of Travel Medicine and Infectious Diseases). Probiotics are considered safe and are readily available.

The digestive troubles don't stop there. Constipation, heartburn and indigestion can all be exacerbated by unhealthy eating and overindulgence. If moderation is not an option, advise customers to go prepared with a range of OTC treatments.

Think back to that family in the car. If they'd visited your pharmacy before they set off, could they have prevented their unscheduled stop and had a happier, healthier holiday?

TRAVELeeze those upsets

Eleanor Bridgman, senior marketing manager with Ernest Jackson, says pharmacies should make it as easy as possible for customers to plan ahead for a healthy holiday: "Offer adults a range of related items to make the journey easier, like Traveleeze travel sickness pastilles for children, which are easy to take without water. Ensure holiday-related P licence medicines are visible, preferably at eye level behind the counter."

Strawberry flavoured Traveleeze soft & chewy pastilles (12.5mg meclozine HCl) can be taken before or during travel. The pharmacy-only pastilles are suitable from the age of two years.

Holiday merchandising tips

Debbie Charman, marketing manager for GSK, says: "The best way for pharmacies to make the most of the holiday/travel opportunity is by merchandising Joyrides and Earcalm in the counter display units to remind consumers to purchase these essential items for their holidays. We are sending out a laminated leave-behind for Earcalm to all pharmacies to help them understand the product in more depth and there is a leaflet available for consumers, providing more details. Pharmacists are also well placed to remind customers about other holiday essentials such as Phillips' Milk of Magnesia Liquid, which is suitable for children aged three and over."

Piriton Allergy Tablets Product Information. Presentation: Tablets containing 4 mg chlorphenamine maleate. **Uses:** Symptomatic relief of chickenpox itch and allergic conditions including hayfever. **Dosage and administration:** *Adults:* 1 tablet every 4-6 hours. *Children aged 6-12:* ½ tablet every 4-6 hours. **Contraindications:** Hypersensitivity. Concurrent or recent treatment with MAOIs. **Precautions:** May increase effects of alcohol. May affect ability to drive and use machinery. Use with caution in prostate, respiratory, liver, cardiovascular and thyroid disease; epilepsy, glaucoma and other eye conditions. **Side effects:** Sedation. Less commonly gastrointestinal disturbances, blurred vision, headaches, urinary retention, dry mouth, muscular incoordination, jaundice, cardiovascular disturbances, chest tightness, dizziness, blood dyscrasias, allergic reactions, tinnitis. Children and the elderly are more prone to the neurological anticholinergic effects. **Pregnancy and lactation:** Consult doctor before use. **Legal category:** P. **Product licence number:** PL 00036/0091. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 30 tablets £3.15, 60 tablets £5.99. **Date of last revision:** February 2008.

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summerhealth08

Here comes the

With so many sun protection products fighting for attention, how do they differ and who should use what? **Lesley Ribbens** looks through the evidence

It's a strange paradox that the feeling of the sun on the skin and the resulting tan boost the mood and give a 'healthy glow', yet too much exposure to UV radiation can kill a person. The development of a tan – that most desirable of holiday souvenirs – indicates the skin has been damaged and is trying to protect itself.

Too much sunshine is, in the majority of cases, the cause of skin cancer. Around 75,000 cases of non-melanoma skin cancer are diagnosed in the UK each year, along with 9,000 cases of melanoma. An estimated 2,300 people die from skin cancer each year in the UK, 78 per cent from melanoma (source: Cancer Research UK). Survival rates are good but, particularly with melanoma, early detection is advantageous. Yet why go through the treatment and the worry when this is such a preventable form of cancer?

This year's annual sun awareness campaign from the British Association of Dermatologists (BAD) aims to promote the early detection message. The key awareness week starts this Monday, May 5, timed to coincide with Euromelanoma day, a Europe-wide day of action on skin cancer prevention. TV presenter Anne Robinson and actress Daisy Bates have given their backing to the BAD campaign to encourage people to look out for changing moles.

Harmful UV radiation can be split into UVA and UVB, sun protection products should cover both. As well as increasing the skin cancer risk, UV radiation damages the elastin in the skin causing wrinkles and premature ageing.

The words 'sunscreen' and 'sunblock' are often used interchangeably but there is a difference. A sunscreen is a suncare product with an SPF2 or higher rating. A sunblock is a physical block offering SPF12 protection or better.

Inorganic or physical agents reflect and scatter UV radiation. Such products form an opaque barrier – think of cricketers daubed in 'warpaints' – often considered cosmetically unacceptable. They remain on the skin's surface and have the advantage that they begin working immediately on application.

Organic filters or chemical sunscreens absorb UV radiation. They convert the UV radiation into infrared and give it back out. Application around 20 minutes prior to going out in the sun is recommended to allow absorption by the skin.

Physical and chemical agents can be combined in the same product.

The level of protection provided by a product is indicated via the SPF (sun protection factor), primarily an indication of UVB protection, and the UVA star system. With the SPF there is a simple correlation between its value and the level of protection against sunburn offered. But the UVA star rating, ranging from 0 to 5, is a ratio between UVB and UVA protection. So be aware that a low SPF product can have a high number of stars. Greatest protection is afforded by high SPF products with a high number of stars.

When recommending products, special consideration should be given to young children and people with sensitive skin, eczema or allergies. For youngsters, the level of alcohol in formulations is a consideration while chemical agents can cause sensitivity in young skin. Lower levels of chemical absorbers can be augmented with the inclusion of physical barriers, as in the Sunsense Toddler variant for children, which includes titanium dioxide to boost its protection to SPF50. Sun protection products are not recommended for infants under six months of age: the baby should be kept out of the sun.

It is recognised that para-aminobenzoic acid (PABA) and its derivatives are allergens and have been known to cause cross-sensitivity to other compounds such as benzocaine. For this reason, PABA and its derivatives have been phased out of most sunscreens. Other chemical agents to look out for are parsol and cinnamates, also associated with sensitivity.

The preservative methyldibromoglutaronitrile has been linked with allergic reactions in recent years, typically swelling, itching and dermatitis. Anyone who has sensitive skin should be advised to patch test any new product they buy and wait for 24 hours before general application, looking out for a stinging or burning sensation or a rash.

Changing labels

A new EU recommendation means labels on sun protection products are changing. The aim is to simplify the SPF system for consumers so descriptions are being added: low protection for SPF6 to 14.9, medium for 15 to 29.9, high for 30 to 49.9 and very high for SPF50+. According to the EU recommendation, the UVA protection for a product should be at least a third of the labelled SPF. Products meeting the requirement can carry the UVA logo – the letters UVA inside a circle.

Phasing in of the new labelling began last summer with around 20 per cent of products using the system. While the guidelines are not binding, the EU cosmetics industry has agreed to adopt them by this summer. The EU feels that consumers will opt for products carrying clearer labelling over those not following the new guidelines, and this will drive manufacturers to comply.

The EU further recommends that:

- **The terms 'sunblock' and '100 per cent protection' be avoided as no product can offer complete protection from UV radiation.**
- **Sunscreens should carry warnings that they do not provide 100 per cent protection such as "Do not stay in the sun too long, even while using a sunscreen product" and "Over-exposure to the sun is a serious health threat".**
- **Claims that there is no need to re-apply the sunscreen should be avoided.**
- **Instructions, explaining how much product should be used, should be included on pack.**

sun...

> "The development of a tan – that most desirable of holiday souvenirs – indicates the skin has been damaged and is trying to protect itself"

Advise on application

You may feel like you're preaching converted, offering advice to custo... sun protection products. Yet many use... apply sufficient cream to provide the level... protection displayed on the label.

An average adult needs to apply 36g – that's six teaspoons – of product to cover the body to match levels used in tests for determining SPF. Areas commonly missed include the back and sides of the neck, temples and ears, says BAD. Application should be repeated every two to three hours.

SPF should be chosen in accordance with skin type; people with a fair skin, light-coloured eyes, blonde or red hair and numerous freckles are most prone to su... damage so require higher SPF products.

There is also a danger that people putting on a suncream may consider themselves invincible and stay in the sun all day. But experts suggest seeking shade between 11am and 3pm when the sun is at its strongest. The Australians sum it up nicely with their long running 'Slip, slop, slap' sun safety message: slip on a shirt, slop on sunscreen and slap on a hat.

Oh, and don't forget the sunglasses...

Product news

Making sense of sunscreens

High protection suncare brand Sunsense is being supported with advertising, online, sampling and PR activity until September. The brand is spreading the 'safe sun' message and encouraging the use of higher SPF products with a minimum of 50 for children and 20 for adults.

The products claim to protect the skin from infrared, visible light, UVA and UVB. They are said to be easy to apply and non-greasy.

More than 80 per cent of UK dermatologists use and recommend Sunsense products, says distributor York Pharma.

The brand claims to be worth more than £1 million and reports sales growth last year of around 20 per cent.

York Pharma; tel: 01477 537596

Spray on aftersun

Sunburn can be sensitive to the touch, so Savlon has launched Savlon Aftersun Foam Spray – a no-rub, no-touch spray.

The formulation cools, soothes and moisturises skin and contains 4 per cent dexpanthenol that helps accelerate cell renewal, says Savlon.

The aftersun spray will be supported by a £2 million campaign and retails at £6.99 for a 150ml spray.

Novartis; tel: 01403 218111

Cool operator

A rescue gel to treat and repair sun damaged skin has been launched by Thornton & Ross. The makers say AfterBURN Sunburn Rescue Gel has osmotic action to draw water to the surface of the skin, helping to rehydrate and treat damaged areas.

The product is designed to aid skin healing, reduce redness, cool irritation and decrease the chances of peeling. It is an odourless, non-sticky and non-staining dermatological gel containing no alcohol, added preservatives or colourings.

The product, which retails at £9.99/75g, will receive an extensive promotional campaign in May, June and July, says T&R.

Thornton & Ross; tel: 01484 842217

BOGOF from Numark

Numark is offering consumers a 'buy one get one free' promotion across its suncare range. Running until the end of June, the offer will help independents compete against large pharmacy chains and the grocery sector, says Numark. POS materials are available to members.

The range spans SPF15, 25 and 30 and includes a cooling gel aftersun variant.

Brand controller Helen Groves adds: "The SPF products have 'peel and seal' labels which offer additional advice on sun safety and therefore promote advice-driven sales from pharmacy."

Numark; tel: 01827 841200

Product news

Have Stingose, will travel

Care Stingose is currently being supported by a consumer promotional campaign, targeting parents, travellers, holidaymakers and outdoor sports enthusiasts. Consumers will be advised to include Care Stingose in first aid kits, beach bags, pockets and car glove compartments, says manufacturer Thornton & Ross.

Care Stingose contains aluminium sulphate 20 per cent, and is designed to work on the cause of bite and sting symptoms, neutralising the venom.

Thornton & Ross; tel: 01484 842217

Senokot in Fybogel switch

Senokot Hi-Fibre has been rebranded to Fybogel Hi-Fibre following feedback from pharmacy. Manufacturer Reckitt Benckiser hopes the move will help minimise consumer confusion by bringing the product, based on the ispaghula husk, under the Fybogel brand name.

Fybogel Hi-Fibre is designed to maintain regularity and relieve constipation. It is a bulking agent containing 80 per cent soluble fibre to absorb water to soften and add bulk to stool, and 20 per cent insoluble fibre to add bulk and promote peristalsis.

Orange and lemon flavours are available, retailing at £2.30/10 or £4.94/30 sachets.

Reckitt Benckiser; tel: 0500 455456

Curanail's summer pitch

Fungal nail infection treatment Curanail (amorolfine 5 per cent) is being supported with a £1.5 million national marketing and PR campaign, aiming to maintain high awareness of the product.

Suitable for treating up to two finger or toe nails, the pharmacy-only lacquer should be applied once a week to infected nails. Over a million people in the UK are believed to be affected with a fungal nail infection, says manufacturer Galderma.

Galderma; tel: 01923 208950

Canesten spells it out

Further Canesten AF products are being rebranded as Canesten AF Dual Action. The new on-pack communication will make clear the dual benefits of the athlete's foot treatments.

A 30g variant of Canesten AF cream was launched under the Dual Action brand last autumn, and the spray and 15g cream will follow in time for summer.

Canesten AF Dual Action contains the antifungal and antibacterial clotrimazole. The spray version is suitable for larger and/or hairy areas.

Ceuta Healthcare; tel: 01202 780558

Sea-Band's new colours

The Sea-Band range of anti-sickness products has been extended with the launch of a camouflage design. The acupressure wristbands are suitable from the age of three and should be positioned so they exert pressure on a point on the inner wrist called the pericardium 6 acupressure point.

An estimated 56 per cent of children aged four to 16 years suffer from travel sickness, reports Sea-Band.

As well as the new camouflage variant, fluorescent, grey and black options are available.

Sea-Band Ltd; tel: 01455 639750

Be bite savvy

The Ben's and After Bite ranges of insect repellents and bite treatments are being promoted this year with ads running in travel titles including Sunday Times Travel, Condé Nast Traveller, Wanderlust and Real Travel. The Ben's offering was recently extended with the launch of a poison extractor (£4.99) and the Ben's 100 repellent gained the maximum star rating in the last Which? magazine review.

David Perkins, managing director of manufacturer Ardern Healthcare, believes there is a need to educate the public about the potential risks from insect bites abroad. Mr Perkins comments: "People are learning the hard way that insect bites away from these shores might threaten your life".

A leaflet, 'What's bugging you?' and a product display box are available.

Ardern Healthcare; tel: 0800 195 7400

TV boost for Senokot

Senokot Dual Relief is receiving a £4.2 million television advertising campaign this year. The product is a recent addition to the Senokot range, which offers gentle relief for constipation sufferers. Senokot Dual Relief (£3.99/20, £6.59/40) contains senna to relieve constipation, and added fennel to relieve the bloating that manufacturer Reckitt Benckiser says many sufferers are also affected by.

Reckitt Benckiser; tel: 0500 455456

Planned £1.5m campaign - stock up now!

Lamisil® Once™ –

To Eliminate Athlete's Foot With Only One Application

With your continued support, we look forward to continue bringing the benefits of a one application treatment to sufferers of Athlete's Foot.

To ensure continued success we will continue to build the product's profile in 2008 through our award winning TV commercial, out of home advertising, digital and consumer press.

LAMISIL ONCE 1% CUTANEOUS SOLUTION. Presentation: Solution containing terbinafine hydrochloride 1.0% w/w. **Indications:** For the treatment of athlete's foot. **Dosage and administration:** The solution is applied once only, between the toes and to the soles and sides of both feet. Not recommended for patients under 18. **Contraindications:** Hypersensitivity to terbinafine or any of the excipients. **Precautions:** For external use only, avoid contact with the face and eyes. In the event of accidental contact with the eyes, rinse thoroughly with running water. In the unlikely event of an allergic reaction, remove the film with an organic solvent and warm soapy water. Not recommended for plantar (moccasin type) tinea pedis. Contains alcohol, keep away from naked flames. **Pregnancy and lactation:** Use in pregnancy only if clearly indicated. Not recommended for use in lactating mothers. **Side effects:** Redness, dryness and irritation at the site of application. Discontinue treatment if an allergic reaction occurs. **Legal category:** P. **Recommended Retail Price:** £9.99 (4g tube). **Product licence number:** PL 0030/0213. **Product licence holder:** Novartis Consumer Health, Wimblehurst Road, Horsham RH12 5AB. **Date of Preparation:** August 2005.

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postscript

Have you or any of your team been up to anything lately? Let us know and send us your photos. Email postscript@cmpmedica.com

Runaway success

Martin Hough proudly displays his London Marathon medal after smashing his personal best time and his fundraising target. Local Queenscourt Hospice stands to gain £3,500, after the Formby pharmacist's fifth London Marathon was sponsored by "regular customers and patients, and people I'd never seen before". Mr Hough, of Ryders Chemist, said: "I see a lot of patients who use the hospice and I wanted to help them out."

Boots staff at the Spalding branch are set to take part in Cancer Research UK's Race for Life events, which take place across the country this summer. If you'll be joining them, send pictures to postscript@cmpmedica.com

Amarjit Gill, of Southall's Gill Chemists, also ran his best time and hopes to have raised £2,500 for Macmillan Cancer Relief.

Web comment of the week

'Reassessment of error referrals needed' Posted by David Morgan, on 25/04/2008

"I cannot think of **any issue** which causes the membership more **real anger and distress** than the aggressive and over-zealous manner in which our own professional body **gleefully drags** unfortunate pharmacists before the **Statutory Committee** for even the most **minor and trivial** misdemeanour"

Have your say on C+D's website
register for free at www.chemistanddruggist.co.uk

A subject close to our heart

British researchers are looking for 150 women volunteers to eat a bar of chocolate a day for a year, to study its effects on the risks of heart disease.

The chocolate has been formulated by a Belgian chocolatier, to provide a higher dose of the heart-protective flavonoids in cocoa (and added soy) than in standard chocolate.

Nonetheless, it's chocolate. Free. What woman could refuse? So if you have any post-menopausal diabetic patients under the age of 70, Postscript suspects they might thank you for steering them towards study leaders at the University of East Anglia. Call 01603 592203 or email fl.yo...@uea.ac.uk.

Moving On

Nucare's Naina Chotai has moved to PharmaPlus as pharmacy services development manager. The group said the appointment came as community pharmacy was hopefully embarking on a more productive future, and it was committed to supporting independent contractors in delivering their new roles.

The NPA has appointed Sukhjit Grewal as head of education and training. Previously head of membership, his immediate plan is to use the findings of a recent member satisfaction survey in the context of education and training.

Heal thyself

A recent report on orangutans has hailed our orange-furred friends as the 'doctors' of the natural world.

Dr Willie Smits, founder of the Borneo Orangutan Survival Foundation, says that our great ape relations use medicinal herbs to cure themselves of ailments ranging from indigestion to malaria.

So convinced is he that Dr Smits has even tried some of these remedies for himself, and has also found that the orangutans line their nests with the twigs of a tree used by local people to ward off mosquitoes.

What Postscript would like to know is: if doctors are orangutans, what does that make pharmacists?
postscript@cmpmedica.com

Enterprising winners

Tej Lalvani, vice-president of Vitabiotics, receives a Queen's Award for Enterprise for the company.

The vitamin company received the award for its achievement in export and international trade.

Vitabiotics chairman, professor Arnold Beckett OBE, said: "Our ambition has always been to create first class scientifically researched products and it is an honour that our achievements have been recognised by Her Majesty the Queen."

The annual business prizes are awarded by the Queen on the advice of the Prime Minister.

This year's medical and pharmaceutical winners also included Owen Mumford, Activa and Pharmaterials.

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